STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155817	A. BUILDING 00 B. WING	05/12/2016

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BARRINGTON OF CARMEL, THE	1335 S GUILFORD ROAD CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the investigation of Complaints IN00198124 and IN00198238. Complaint IN00198124-Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F365. Complaint IN00198238-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F323 and F508. Survey dates: May 4, 5, 6, 9, 10, 11 and 12, 2016 Facility number: 013212 Provider number: 155817 AIM number: N/A Census bed type: SNF: 39 Residential: 66 Total: 105 Census payor type: Medicare: 16 Other: 23	F 0000	Please accept this 2567 Plan of Correction for the HealthSurvey ending May 12, 2016 as a Provider's Letter of Credible Allegation. This provider respectfully requestsconsideration for paper compliance in lieu of a revisit survey for this Plan ofCorrection with a completion date of May 27, 2016. This Plan of Correction constitutes my writtenallegation of compliance for the deficiencies cited. However, submissionof this Plan of Correction is not an admission that a deficiency exists or thatone was cited correctly. This Plan of Correction is submitted to meetrequirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 39 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on May 18, 2016.			
F 0156 SS=D Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in			

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	paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and			

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	non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure residents were informed timely when medicare services were to end for 1 of 3 residents reviewed for liability and appeal notices (Resident #76). Finding includes: Resident #76's "Notice of Medicare Non-Coverage" letter for services indicated services were to end on 11/23/15. The form was signed by the resident on 11/23/15. During an interview on 5/10/16 at 2:01 p.m., the Director of Social Services indicated the notices for non-coverage should be completed 2 days before the expiration of services. She also indicated she did not have an explanation regarding Resident #76's letter as it was not completed timely.	F 0156	**F156 Notice ofRights, Rules, Services, Charges It is the practiceof this facility to ensure residents are informed timely when Medicare servicesare to end What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Resident #76 no longer resides at the Community. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·Social Services Director and designee have beenre-educated	05/27/2016

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	During an interview on 5/10/16 at 3:52 p.m., the MDS (Minimum Data Set) Coordinator indicated the notice for non-coverage letters should be completed within 48 hours. He also indicated, he was unaware why Resident #76's notification was not given within the allotted time frame. 3.1- 4(f)(3)		on informing residents/families on Medicare's non-coverageliability and appeal notice rights. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The MDS Coordinator or designee will conduct an auditon 3 Medicare residents that are discharging to ensure the Medicarenon-coverage letter is signed in allotted time frame weekly for four weeks, monthlyfor three months and then quarterlythereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form			

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	of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to ensure a Physician was notified of an X-ray result in a timely manner and failed to ensure a family member was notified of a fall in a timely manner for 1 of 2 residents reviewed for notification of change (Resident C). Findings include: An "Occurrence Report" dated 4/8/16 at 9:00 a.m., indicated Resident C had a fall in her room during a transfer with CNA #8 as a witness. "At 9:00am today resident transferring from w/c [wheelchair] to recliner with assist x [times] 1. During transfer resident lost her balance and began to fall to the right. CNA attempt to assist resident and lowered resident to floor. Resident did	F 0157	**F157 Notify ofChanges (Injury /Decline/Room, etc.) What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident C- no longer resides at the community. ·X-ray company was notified of need for x-ray. **How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action (s) will be taken:** ·All residents with falls have the potential tobe affected by the alleged deficient practice. ·A review of residents with falls, in the past 90days, was completed. No residents wereidentified as having untimely notifications.	05/27/2016

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	hit her right shoulder and arm on the floor. Resident c/o [complained of] of severe pain to right shoulder. No other s/s [signs/symptoms] of injury noted at this time. PPP [peripheral pulses present] x4. Assist x 2 to remove resident from floor. Resident displayed limited ROM [range of motion] in RUE [right upper extremity] compared with LUE [left upper extremity]. NP [Nurse Practitioner] and daughter notified. N. O. [new order] obtained for x-ray of right shoulder, elbow and humerus." Resident statement of what happened was documented on 4/11/16 at 12:22 p.m., "I don't know it just hurts." Resident guarding right shoulder following fall. Witness statement of what happened was documented on 4/11/16 at 12:22 p.m., "I was transferring resident from her w/c to the recliner when she started leaning to the right. I attempt to 'catch her' but I couldn't so I assisted in lowering her to the floor. Resident landed on her right shoulder and right upper extremity. Resident did not hit her head. Assist x 2 to remove from floor." The injuries section indicated the resident displayed limited range of motion and complaints of pain in the right shoulder and arm following the fall. The NP was notified of the fall on 4/8/16 at 9:15 a.m., with new orders. The family member was notified of the fall on 4/8/16 at 12:00		**What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Re-education was given to licensed nurses onnotification of changes to physician and family or responsible party. ·Re-education of licensed nurses regarding followup of x-rays, tests, lab work, and change of condition has been completed. ·Re-education was provided to licensed nurses regardingdocumentation of all unusual occurrences and changes of condition. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The Director of Nursing Services (DNS) orDesignee will conduct audits on 3 residents to ensure that changes incondition/incidents have been communicated timely to appropriatePOA/responsible party on notification, follow up, and documentation, weekly forfour weeks, monthly for three months and then quarterly thereafter for 12months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	p.m. Resident C's record was reviewed on 5/9/16 at 4:18 p.m. Diagnoses included, but were not limited to, generalized muscle weakness, atrial fibrillation and dementia. Resident C's Physician orders included, but were not limited to, the following orders: 4/8/16--Three view shoulder X-ray of the right shoulder and two view humerus X-ray for a recent fall and severe pain. (The stat box on the order was not checked) 4/8/16--X-ray of right elbow, right radius and ulna. (The stat box on the order was not checked). 4/8/16--May send to ER for X-ray of right elbow and right radius and ulna, ice to right elbow every 4 hours as needed for pain for 20 minutes--avoid direct contact, sling for right upper extremity continually for pain control. A Radiology Report dated 4/9/16, indicated the resident had a shoulder X-ray completed on 4/9/16, for pain after a fall. The results indicated there was an acute mildly displaced proximal humeral fracture. A Radiology Report dated 4/9/16,			

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	indicated the resident had an elbow X-ray completed on 4/9/16, which indicated there was acute mildly displaced fracture of the distal humerus. There was also soft tissue swelling. A Radiology Report dated 4/9/16, indicated the resident had a forearm X-ray completed after a fall. The results indicated there was no fracture or dislocation. These final X-ray reports were faxed to the facility on 4/9/16 at 11:49 a.m., and the report results were called to the NP on call on 4/9/16 at 3:00 p.m. During an interview on 5/10/16 at 9:38 a.m., Customer Service Dispatcher #19 from (Name of Radiology company) indicated the Radiology reports were faxed to the facility on 4/9/16 at 11:49 a.m. During an interview on 5/10/16 at 3:41 p.m., the Director of Nursing (DON) indicated the nurse probably did not know the X-ray results were faxed to the facility. She indicated (Name of Radiology company) would not call when the test results came in, so she probably had been looking for the X-ray results in the morning and they did not come, then they came in the afternoon and the nurse			

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	did not realize it, but that was no excuse for not getting the results and notifying the doctor. During an interview on 5/10/16 at 4:00 p.m., RN #11 indicated the resident's family member came to the facility immediately after she was notified the resident fell. During an interview on 5/11/16 at 11:09 a.m., the DON indicated she expected the nurses to notify the resident's Physician in the event of a fall in case they need orders, then carry out any orders, which needed to be completed, then notify the resident's family member in a reasonable time frame. During an interview, RN #11 indicated she had notified the NP on 4/8/16 at 9:15 a.m., of the resident's fall and notified the resident's family member of the fall on 4/8/16 at 12:00 p.m. A current policy titled "Resident Rights: Notification of Changes" dated 11/1/13, provided by the DON on 5/11/16 at 3:45 p.m., indicated "Objective: To protect the right of the resident to be notified of changes...Standard: Licensed Nursing Home will immediately notify the resident, consult with the resident's physician, and if known, notify the			

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	resident's legal representative or an interested family member of changes. Guideline:.. 5. Notification will occur when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention...c. A need to alter treatment significantly (i.e. a need to discontinue an existing for of treatment due to adverse consequences, or to commence a new form of treatment...." This Federal tag relates to Complaint IN00198238. 3.1-5(a)(1) 3.1-5(a)(2)			
F 0176 SS=D Bldg. 00	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to ensure a resident was assessed and evaluated to self administer his nebulizer treatment for 2 of 2 observations of nebulizer treatments (Resident #61).	F 0176	**F176 ResidentSelf-Administer Drugs if Deemed Safe What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident # 61 was assessed for lung and breathsounds.	05/27/2016

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	Finding includes: On 5/04/2016 at 11:24 a.m., Resident #61 was observed in his room sitting in his wheelchair receiving a nebulizer treatment with no staff present. On 5/4/16 at 11:36 a.m., LPN #1 was observed to enter Resident #61's room and turn off the nebulizer treatment and exit the room. On 5/10/16 at 11:42 a.m., Resident #61 was observed in his room sitting in his wheelchair receiving a nebulizer treatment with no staff present. On 5/10/16 at 11:47 a.m., LPN #1 was observed to enter Resident #61's room and turn off the nebulizer treatment. At this same time LPN #1 indicated she was unaware she was to remain with the resident during the treatment and would set her timer to return to the resident's room after 13 to 14 minutes with the treatment completed generally in 15 minutes. On 5/11/16 at 11:15 a.m., the Director of Nursing indicated Resident #61 did not have a self medication administration evaluation prior to the evaluation completed after the reported morning administration without staff present on 5/10/16.		Assessment revealed no negativeoutcomes. Resident was givenself-administration of drugs assessment and passed during survey. ·Re-education was given to nurse during Statesurvey to ensure compliance with standard. ·Re-education was given to licensed nursesregarding nebulizer treatments. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action (s) will be taken:** ·Residents that require a nebulizer treatment havethe potential to be affected. ·Residents currently receiving nebulizertreatments have had orders reviewed, assessments completed, and self-administration reviewed. ·Residents requesting to perform their ownnebulizer treatment have had a self-administration of medication formcompleted as well and their BIMS reviewed. If the resident was deemed appropriate, the physician was notified fororders. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Licensed Nurses were in-serviced by Director ofNursing or Designee on policy and	

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	Resident #61's record was reviewed on 5/9/16 at 3:00 p.m. The resident's diagnoses included, but were not limited to, anxiety, cardiovascular disease, and cognitive communication deficit. The physician order, dated 5/2/16, indicated Duonebs (breathing treatment) every 6 hours for 72 hours, then as needed for cough and wheezing. No information was indicated if the resident had been assessed and evaluated for self-administration of medication. The "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES" policy for the "NEBULIZER" was provided by the Director of Nursing on 5/1016 at 4:40 p.m. This current policy indicated the following: "...N. Remain with the resident for the treatment unless the resident has been assessed and authorized to self- administer....." The "Self Administration of Drugs" policy was provided by the Director of Nursing on 5/1016 at 4:40 p.m. This current policy indicated the following: "...Standard: The resident may self-administer drugs if the interdisciplinary care team and the physician have determined the practice is safe.		procedure for administering nebulizertreatments. ·Nurses in-serviced regarding Standard andGuidelines on nebulizer treatments. Return demonstration was also completed. ·Newly hired nurses will receive the training asthey are hired. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The Director of Nursing or Designee will conducta nebulizer treatment audit 3 times weekly for four weeks on rotating shifts, thenmonthly for three months and then quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	Guideline: 1. If a resident requests to self-administer drugs, the interdisciplinary care team will determine if it is safe for the resident to self-administer before the resident may exercise that right ...3. Documentation will be placed in the resident's clinical record. ...6. A physician order is required for a resident to self-administer drugs....." 3.1-11(a)			
F 0244 SS=E Bldg. 00	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on observation, interview and record review, the facility failed to ensure Resident Council grievances concerning the serving of meals in the dining room were reconciled for 10 of 10 months of Resident Council minutes reviewed. This deficiency affected 6 of 20 residents observed in the main dining room (Resident #18, #7, #109, #108, M and #43). Findings include:	F 0244	**F244 Listen/Act ongroup grievance/recommendation** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Resident's 18, 7, 109, M, and 43, will be servedin the dining room timely. ·Resident 108 no longer resides at the Community. ·Reviewed Resident council minutes for the last10 months, an	05/27/2016

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	On 5/4/16 from 11:50 a.m., to 1:00 p.m., during the dining observation in the main dining room, the following was observed: At 11:50 a.m., Resident #18 was sitting at the table waiting for her meal. At 12:30 p.m., she continued to wait for a meal and indicated she was hungry. At 12:34 p.m., she received her meal. At the rectangular table, Resident #7 and Resident #109, were served their meal tray at 12:44 p.m. As the desserts from the dessert cart were being served to other residents, Resident #108 requested and received her dessert at 12:55 p.m. She received her meal tray at 12:56 p.m. At 1:00 p.m., all residents had received a meal tray. Twenty residents were observed remaining in the dining room. On 5/9/2016 from 11:42 a.m., to 1:00 p.m., during the dining observation in the main dining room, the following was observed: Resident M was observed to receive her meal at 12:25 p.m. RN #11 was observed to be feeding Resident #43 as one unidentified CNA remained to pass the meal trays for the remaining 4 tables. At 11:42 a.m., Resident #18 was sitting		action plan developed to address concerns. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken**: ·All residents have the potential to be affectedby the alleged deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·Managers have been assigned to assist withmeals. Nursing staff and Dietary staff have been educated on taking residentsorders and serving the residents timely by the Dining ServicesDirector/designee. ·Director of Social Services or designee duringresident council will ask residents if meal service is improving, adjustmentswill be made as necessary. ·Managers have been assigned to assist withmeals. Nursing staff and Dietary staff have been educated on taking residentsorders and serving the residents timely. ·Managers will address concerns from residentcouncil meetings on a written form. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put**	

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	at the table waiting for her meal. She was served her meal at 1:00 p.m., and was the last person to be served. On 5/10/16 at 10:05 a.m., during an interview RN #11 indicated after the CNA's brought the residents down to the dining room, the CNA should take their order and submit the tickets in the order of who arrived first. On 5/11/16 at 11:43 a.m., during an interview CNA #3 indicated it depended on who the staff were in the kitchen and dining room as to how the meals were served. CNA #4 indicated the dining room was divided into sections, but staff needed to work together. CNA #3 indicated on 5/4/16 (Monday), the meal tickets were mixed up and caused a delay. The Resident Council minutes were provided and reviewed on 5/6/16 at 9:30 a.m. They indicated the following: The 7/28/15, meeting "...Multiple CNA's assisting/feeding residents-wonder why so many need to feed-Director of Nursing (DON) is working on assignments...Discussed assignments of CNA's during meal times-presented the floor plan of what we will be inservicing the staff on...Discussed that plates are hot		**into place:** ·Administrator or designee will audit mealservice 2 times per week for 3 months and then twice a month for 3 months,twice quarterly thereafter for 12 months. ·Administrator or designee will review residentcouncil concerns and ensure they are addressed. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	sometimes-discussed food temps...." The 8/26/15, meeting "...Managers are to be in the dining room on scheduled days and section assignments are to be enforced by the DR manager...RD is focusing on diet production, staff training, reading tray cards...getting new staff next week; job task responsibilities...." The 9/23/15, meeting "...Dietary working on new schedule for Dining Room Managers; positive feedback on servers...working on production, service and mobility in the kitchen...training continues with new servers...goal is for residents to have food in 15-20 minutes from time of order; staff now writing time order was taken on ticket; staff to take one table of orders to kitchen before taking next order...." The 10/28/16, meeting "...positive comments received about timeliness of meals; desserts sometimes passed on cart, sometimes not; staff don't know what is being served for dessert...tickets need to be turned in after each table...nursing and dining services will schedule meeting to work on increasing communication, processes and cooperation between servers and CNA's...."			

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	The 11/25/16, meeting "...dining...staff need to be more organized; drinks not served timely; portions small at times; wings dry; staff need to use dining room serving chart; would like to see a dining manager hired to oversee all meals...." The 12/30/16, meeting "...dining services-Assistant Executive Director is currently serving as interim Dining Services Director. He is working on staffing...Residents were very complimentary of last evenings meal and service...." The 1/27/16, meeting "...discussed replacement of servers, RD noted they are in the process of hiring new staff with focus on customer services, organization, teamwork, accountability, efficiency and production; they will begin using a person from 12-8 to assist with food production, taking orders for the first half hour, then clearing dishes and bussing tables...." The 2/24/16, meeting "...Dining Services-Utility person is scheduled from 11:30 a.m. to 8:00 p.m. to assist with the drink cart, cleaning, and specific job tasks; would like to see more training for CNA's so they can contribute to the 'fine dining' experience; use of beverage cart at meal time should improve			

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	efficiency...." The 3/23/16, meeting "...Dining Services-Service is more prompt; Attendees from 'round table' offered to come to dinner at 5:30 p.m. to help spread out service...." The 4/27/16, meeting "...Dining Services-tables are not always set, but improvement has been noted; need more silverware rolled and available for room trays...From RD: Director of Dining Services and Chef will attend next meeting; changes are being made with cook staff and floaters; meetings are being held with staff regarding 'best practices' and customer service and nurse consultant has had much input on this; duties are being specified to improve efficiency; production and time management...." During an interview on 5/11/16 at 12:08 p.m., the Director of Social Services indicated she requested a representative from each discipline to attend the meetings to address the issues at the same time. No follow up forms had been used due to the department heads preferred not to use them. She indicated she agreed the serving of meals in the dining room had been and remained an issue with the			

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	residents in the main dining room. 3.1-3(l)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure preventative interventions were in place to prevent a new pressure ulcer to the right heel for 1 of 3 residents (Resident #31) and lacked an appropriate assessment of a pressure ulcer for 1 of 3 residents (Resident #89) reviewed for pressure ulcers. Resident #31's right heel pressure ulcer progressed from a Stage II to an Unstageable wound requiring antibiotics for cellulitis to the wound and bone was present in the wound bed. Findings include: 1. During an interview on 5/5/16 at	F 0314	**F314 Treatment/Svcsto Prevent/Heal Pressure Sores.** **What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident # 31 - had a full skin assessmentsperformed along with pressure ulcer risk assessment. Appropriate revisions/changes were made tothe care plans to reflect all pressure ulcer prevention and interventions asneeded. Resident had unavoidable andPVD diagnoses. The C.N.A. assignmentsheet was updated with current pressure reducing devices to be used. Resident was seen by wound physician	05/27/2016

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	11:35 a.m., the Director of Nursing (DON) indicated Resident #31 had an acquired (began at the facility) pressure ulcer on the right foot, which was an Unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the ulcer bed) Note: Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined. Stable (dry, adherent, intact without erytherma or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed) ulcer and is now a Stage 4 and a wound vac (a technique that uses a vacuum dressing to promote healing in wounds) was started this week. Resident 31's record was reviewed on 5/9/16 at 8:42 a.m. Diagnoses included, but were not limited to, pressure ulcer right heel, cellulitis right medial heel, osteomylitis right ankle and foot and peripheral vascular disease. An IDT team note dated 5/7/16, indicated the resident had an open area to the right heel, which measured 4.8 x 4.2 x 0.2 cm. He had a wound vac to the wound bed. The wound base was being treated with a piece of white foam over the bone and		andtherapist to assist for further interventions, family education completed andis involved with plan of care. ·Resident # 89 - no longer resides at thecommunity. ·Nursing staff have been re-educated on thedocumentation standards for wound assessments, measurements, staging and descriptions. ·Wound care physician will continue to giveperiodic education on staging of wounds as well as proper dressings, vitamins,minerals, and other supplements. **How other residents having the potential to be affected by the samedeficient practice will be identified and what corrective action (s) will betaken:** ·All resident have the potential to be affectedby the alleged deficient practice. Pressure risk assessments and skin assessments were completed for currentresidents by nursing team. Thoseresidents identified to be at risk had care plans reviewed and updated toensure appropriate interventions were in place. ·Wound Doctor is coming to do rounds with woundteam (DON, ADON, MDS, HFA) for appropriate preventative interventions andappropriate assessment of pressure ulcers. ·Nursing staff has been re-educated on thedocumentation	

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	black sponge to granulation tissue with the wound vac set at 125 mmHg continuous pressure as the primary dressing. A small amount of bloody drainage was noted on the old dressing. The right heel wound originated from a "rug burn" when the resident used his heels as leverage when he was using his wheelchair for locomotion. He was followed by a wound clinic. He used Multipodus boots to the right heel for pressure relief after the wound was formed. Physician orders included, but were not limited to, the following orders: 4/26/16--Augmentin (an antibiotic medication) 875 mg (milligrams)-125 mg one tablet by mouth twice daily for 14 days for diagnosis of cellulitis to the right medial heel. 5/6/16--Apply duoderm (a protective dressing) to surrounding tissue of wound on right heel prior to applying wound vac. 5/10/16--Use NPWT (Negative-pressure wound therapy-cleanse wound on the right heel with Normal Saline. Apply white foam over bone, then black sponge to granulation tissue and set it at 125 mmHg (millimeters of mercury) continuous pressure as the primary dressing to the wound. Change the wound vac three times a week for		standards for wound staging descriptions. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Facility will follow recommendations per Wound Doctor. ·Nursing continue to complete skin assessments uponadmission, weekly, and with significant changes. ·Nursing staff re-educated on pressure ulcerprevention, interventions, wound staging and assessment. ·The Director of Nursing and or her Designee willmonitor physician orders regarding pressure ulcer appropriate assessment andpreventative interventions by doing weekly wound rounds. ·Re-educate C.N.A.'s to continue reportingdirectly to the charge nurse any changes they observe in a resident's skincondition as well as documenting on shower sheets. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The Director of Nursing and or her Designee willconduct a skin audit on all residents with pressure ulcertreatments/interventions and	

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	diagnosis of ulcer to right medial heel. The resident had a Care Plan dated 1/12/16, which addressed the problem he actually had impaired skin integrity and had an unstageable area to his right heel. Approaches indicated "1/12/16--1. Wound care/dressing change as ordered. See Physician orders. 2. Provide pressure relieving devices (bed, chair cushion and boots to bilateral feet). 3. Turn and reposition every two hours and as needed...." The resident had a Care Plan dated 4/28/16, which addressed the problem he had cellulitis to his right heel. Approaches indicated "4/28/16--...2. Administer antibiotics as ordered. Observe for side effects and effectiveness and report concerns/worsening symptoms to physician promptly. 3. Implement & [and] maintain appropriate precautions as outlined per CDC [Centers for Disease Control] guidelines as indicated. 4. Augumentin 875 mg-125 mg tablet (Amoxicillin-potclavulanate), 1 tablet PO [by mouth] BID [twice daily] daily for 12 days, dx [diagnosis] cellulitis to the right medial heel...." Resident #31's notes for the following dates indicated the following:		wound staging weekly for four weeks, monthly forthree months and then quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	11/4/15-- A Skin Evaluation note indicated the resident had an unstageable pressure ulcer to the right heel. The treatment was protective dry dressing applied and heelz up pressure relief device in place. He had a reoccurring reddened right heel, he was already on a pressure reducing mattress with his heels elevated while in bed and turn every two hours and as needed. The pressure ulcer measured 2.0 x 1.5 x 0 cm (centimeters). The wound edges were approximated (the edges of the wound were brought together without areas of separation. 11/11/15--A Skin Evaluation note indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Note: This stage soul not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.) pressure ulcer to his right heel. The treatment was Medihoney (a debridement medication) change every day. The tissue type was epithelial (sheet of cells that covers a body surface or lines a body cavity). The drainage was a light amount. The pressure ulcer measured 2.0 x 1.5 x 0.1 cm.			

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	11/11/16 at 3:41 p.m., IDT (Interdisciplinary Team) note dated 11/11/16 at 3:41 p.m., indicated the heels up intervention was considered ineffective because the resident developed an open area to his right heel, so the MD was notified and the heels up was discontinued and an order for heel protectors was obtained. IDT wound note dated 12/10/15, indicated the pressure ulcer on the resident's right heel had a red wound base and the surrounding tissue had a yellow scab. The wound was a Stage II. The treatment was Medihoney and the resident wore heel protectors at all times. 12/12/15--A Skin Evaluation note indicated the resident had a Stage II pressure ulcer to the right heel. The treatment was Medihoney change every day. The tissue type was epithelial with no drainage. The wound measured 0.3 x 0.3 x 0.1 cm. IDT wound note dated 12/17/15 at 12:20 p.m., indicated the foam heel boots order was changed to while the resident was in bed, so he could maintain his independence with locomotion in his wheelchair. 12/30/15--A Skin Evaluation note			

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	indicated the resident had a reddened area on the right heel with a dark discoloration, the area was blanching when palpated. The treatment was to wrap the wound with kerlix and apply a foam boot to the right heel when in bed. The skin condition indicated it was a bruise. The wound edge was pink and surrounding healthy skin. Tissue type was 100% granulation (Pink-red tissue that fills an open wound when it begins to heal). IDT wound note dated 1/2/16, indicated the pressure ulcer on the right heel was not healed and continued to improve. The wound base was red. The surrounding tissue to the right heel was red from a rug burn from when the resident used his heels as leverage when he was propelling his wheelchair himself. The right heel treatment was changed to wrap the right heel with kerlix to help cushion the heel when he was propelling himself. Medihoney was the treatment. 1/8/16--A Skin Evaluation note indicated the resident had a Suspected Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and sheer. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as			

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	compared to adjacent tissues) pressure ulcer. The description was dark purple discoloration referred to as the distal right heel wound. The tissue type was epithelial. The ulcer measured 4.8 x 5.8 x 0.1 cm. 1/8/16--A Skin Evaluation note indicated the resident had a Stage II pressure ulcer to his right heel described as an open area to the right heel referred to as the proximal wound. The tissue type was epithelial. The wound measured 0.2 x 0.2 x 0.1 cm. 1/15/16--A Skin Evaluation note indicated the resident had an Unstageable pressure ulcer to his right heel described as 40% black eschar (Thick, leathery necrotic or devitalized tissue, frequently black or brown in color) and 60% granulation. The tissue type was necrotic/Eschar The wound measured 6.2 x 5.8 x 0.1 cm. The treatment was Medihoney change every day. IDT note dated 1/16/16, indicated the pressure ulcers on the right heel around the proximal and the distal heel open areas have integrated and will be referred to as a right heel unstageable pressure ulcer. The right heel pressure ulcer measured 6.2 x 5.8 cm. The right heel presented with 40% black eschar and			

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	60% granulation. The right heel wound originated from a rug burn when the resident used his heels as leverage when he was propelling his wheelchair. Treatment was not effective and was changed to Medihoney daily, foam boots continued to be used to relieve pressure from the heels when the resident was in the bed only. A Podiatry note dated 1/20/16, indicated the chief complaint was Resident #31 was seen for an evaluation and treatment of the right heel ulcer. Nursing stated the resident had this wound for about a month. The wound was treated with Medihoney alginate. The ulcer was located to the right posterior medial heel. Mostly soft black eschar open at the distal aspect, moderate amount of serosanguineous drainage, no odor, mild surrounding erytherma, . The wound measured 3.7 x 5.0 cm. The Podiatrist was unable to determine the depth. Diagnosis was pressure ulcer of right heel, unstageable. Treatment plan: Continue Medihoney Alginate daily as previously ordered by PCP (Primary Care Physician). Waffle boot to be ordered by nursing to offload pressure on heel. Patient was not cooperative with floating his feet and has been wearing foot pillows to protect heels and feet. Needs waffle boot to offload heel pressure right			

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	foot. IDT wound note dated 1/27/16 at 9:20 a.m., indicated the resident was seen by the podiatrist on 1/27/16, and an order to keep the black eschar dry with betadine application twice a day and to wear heel protectors at all times to prevent pressure to affected heel. A Podiatrist note dated 1/27/16, indicated the chief complaint was the resident was seen for an evaluation of a right heel ulcer being treated with Medihoney. The ulcer was located to the right posterior medial heel. The wound tissue was 100% black eschar. The wound measured approximately 4.0 x 5.0 cm. Unable to determine the depth. The wound was unstageable. The diagnosis was pressure ulcer of right heel, unstageable. Care Plan: Discontinue Medihoney to heel wound. Apply providone/iodine (betadine) swab to heel wound twice a day and cover with 4 x 4 , wrap with kerlix. The resident received new heel protectors today that offload pressure on heels. The patient was to wear these bilateral heel protectors at all times. X-ray ordered to r/o (rule out) osteomylitis. Arterial Doppler BLE (bilateral lower extremity) ordered to asses arterial status.			

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	IDT wound note dated 2/3/16 at 11:47 a.m., indicated the findings of the arterial Doppler revealed disseminated arteriosclerosis disease, which put the resident at compromised healing to the right heel. Results of the Doppler and effects of arterial insufficiency to healing of the right heel were discussed with his wife. He continued to wear the heel protectors at all times to prevent pressure to the affected heel. 2/6/16--A Skin Evaluation note indicated the resident had an Unstageable pressure ulcer to his right heel described as 100% black eschar. The wound measured 6.2 x 5.8 x 0.1 cm. The tissue type was necrotic/eschar. The treatment was to apply Betadine twice a day to the right heel, then wrap with Kerlix. 3/5/16--A Skin Evaluation note indicated the resident had an Unstageable pressure ulcer to his right heel described as 100% black eschar. The wound measured 5.2 x 4.9 x 0.4 cm. The tissue type was necrotic/eschar. The treatment was to apply betadine two times a day to right heel, wrap with kerlix. 3/20/16--A Skin Evaluation note indicated the resident had an Unstageable pressure ulcer described as 100% black eschar. The tissue type was			

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	necrotic/eschar. The wound measured 5.0 x 4.2 x 0.4 cm. The treatment was cleanse with normal saline, apply Santyl, then Hydrogel dressing and wrap with Kerlix. 3/24/16--A Skin Evaluation note indicated the resident had an unstageable pressure ulcer to the right heel described as 10% black eschar and 90% yellow slough. The tissue type was necrotic/eschar. The wound measured 4.9 x 4.0 x 0.4 cm. The treatment was cleanse with normal saline, apply Santyl, then Hydrogel dressing and wrap with Kerlix. 3/30/16--A Skin Evaluation note indicated the resident had an unstageable pressure ulcer to the right heel described as 10% black eschar, 40% granulation and 40% yellow slough. Tissue type was necrotic/eschar. The wound measured 4.7 x 3.8 x 0.4 cm. The treatment was cleanse with normal saline, apply Santyl then Hydrogel dressing and wrap with Kerlix. 4/5/16--A Skin Evaluation note indicated the resident had a Stage 4 pressure ulcer to the right heel described as 50% granulation and 50% yellow slough. Tissue type was necrotic/eschar. The wound measured 6.0 x 0.6 cm. The treatment was cleanse with normal saline;			

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	apply Santyl, then Hydrogel dressing, foam heel and wrap with Kerlix. On 4/5/16 at 10:42 p.m., the resident was started on Cipro (an antibiotic medication) for a wound infection to the right heel. 4/15/16--A Skin Evaluation note indicated the resident had a Stage 4 pressure ulcer to the right heel described as 90% granulation and 100% yellow slough. Tissue type necrotic/eschar. The wound measured 4.3 x 3.6 x 0.6 cm. The treatment was cleanse with normal saline then apply Santyl, then Hydrogel dressing, foam heel and wrap with Kerlix. 4/23/16--A Skin Evaluation note indicated the resident had a Stage 4 pressure ulcer to the right heel described as retention dressing in place since 4/19/16, when the resident had a graft placement to this right heel. The treatment was to leave the dressing intact, wound clinic will remove on Tuesday. Tissue type was necrotic/eschar. No drainage. The wound measured 4.3 x 3.6 x 0.6 cm. 4/29/15--A Skin Evaluation note indicated the resident had a Stage 4 pressure ulcer to the right heel described			

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	as skin graft on wound base. Tissue type was necrotic/eschar. The wound measured 4.8 x 4.0 x 0.2 cm. The treatment was not written on note. . On 5/9/16 at 10:27 a.m., RN #11 and the DON was observed changing Resident #31's dressing to his right heel. The resident's right heel had a pressure ulcer the size of a medium egg with beefy red tissue with a white colored tissue extending from the 1-4 o'clock position. A new wound vac dressing was applied to the resident's right heel. RN #11 indicated, at that time she was placing the white colored square foam piece over bone and the black foam over granulation tissue. Resident #31's record lacked documentation indicating his wife was educated regarding the risks versus the benefits of him propelling himself without shoes or slippers to prevent an unstageable pressure ulcer to his right heel, documentation regarding other interventions attempted to prevent pressure to the resident's bilateral heels while sitting in his wheelchair with his feet on the footrests and to prevent further skin breakdown. During an interview on 5/11/16 at 9:04 a.m., the DON indicated the "rug burn"			

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	from 1/2/16, contributed to the right heel wound, but did not cause the wound She indicated Resident #31 was allowed to continue to use his feet to propel himself because he wanted to propel himself around his room. She indicated staff always pushed him outside his room. She indicated there was no padding or other intervention on the footrests while the resident was sitting up in his wheelchair to prevent the resident's heels from resting on the footrests itself while he sat up in his wheelchair for meals or while sitting up in the wheelchair with the foot rests where his heels rested on the footrests. She indicated on 1/8/16, the right heel distal wound originated from a "rug burn" when the resident used his heels as leverage when he was propelling in his wheelchair. The area presented as a dark purple area of pressure. The resident wore the foam boots to relieve pressure from his right heel while he was in bed. She indicated when he was taken back to his room the staff took his foot pedals off his wheelchair,so he could have his independence to move around in his room, so he could propel himself around his room. She indicated the proximal wound was caused from the pressure from the bed where the resident would turn himself and the heelz up was not effective and he had pressure on his heel. The DON indicated at that time, on			

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	4/8/16, the right heel pressure ulcer was down graded to a Stage IV. 2. On 05/11/2016 at 11:51 a.m., Resident #89's record was completed. Diagnoses included but were not limited to, bilateral pubic rami (pelvic bones) fractures, chronic back pain and an ulcer of the right buttock. (Resident #89) On 12/28/15 the "Skin Evaluation Record" indicated: " Site description: Buttock. Category: Skin condition. Description: Redness and excoriation to bilateral buttocks ... Treatment: Calmo (a skin protectant), turn every 2 hours and monitor. " The skin evaluation record lacked measurements of the area. On 12/30/15, an "IDT (Interdisciplinary Team) Wound Review" indicated, " ...Resident is followed for the first time in wound rounds and follow up for a new admission. Bilateral buttocks noted with excoriation ...Excoriation to buttocks is being treated with calmoseptine ...Resident's mobility is very compromised ...Due to residents' weakened state resident has been in bed 75% of the time .... " The wound review note lacked wound measurements. On 1/8/16, an "IDT Wound Review"			

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	indicated, "...Resident is followed for excoriation to bilateral buttocks ...Excoriation to buttocks has improved and continue to be treated with calmoseptine ...Endurance has improved and resident is able to sit up in chair for upto (sic) an hour .... " The wound review note lacked wound measurements for this date. A Progress Note dated 1/14/2016, indicated, "...Chief Complaint: Nursing report of shearing. (Interaction of gravity and friction against the surface of the skin) This is a new problem, is acute. Location of the problem is buttock. The problem has occurred for 2 days ... [Resident name] reports; the severity of the problem as severe. [Resident name] reports the problem is experienced at rest. Sitting up is an aggravating factor. Nothing is a relieving factor. Resident does not like repositioning ....Problem list ...13 ...Pressure ulcer ...unspecified stage .... " The Progress Note lacked wound assessment or measurement. A physician order dated 1/14/16, indicated to cleanse right buttock with NS (normal saline), pat dry, apply Medihoney (a wound debrider) and Mepilex (a type of wound dressing) dressing change every other day.			

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	The "Skin evaluation record" dated 1/15/16 indicated, "...Site description right buttock. Category: Partial Thickness wound. Type pressure ulcer. Treatment: medihoney with Mepilex. Description: stage 2, wound base with scattered (sic) yellow slough. Length 1.0 cm, Width 4.8 cm, Depth 0.1 cm ...Where occurred HC (Health Center). Where treated HC and cause Pressure. Wound edge healthy. Surrounding skin healthy. Tissue type =slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist, and light in color; may be stringy) , exudate (drainage) amount=0...." The "IDT Wound Review" dated 1/16/16, indicated, " ...Resident is followed for excoriation to bilateral buttocks ...Right buttock is being down-graded to a stage 2 pressure ulcer (A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue; a Stage 2 pressure ulcer is defined as; partial thickness loss of the dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Note; This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation). NP (Nurse Practitioner) was notified of change in			

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	clinical condition of right buttock. Heassessed (sic) resident and a new order for medihoney with Mepilx (sic) dressing was obtained and implemented. Wound base with scattered yellow slough with no drainage or odor...." A physician order dated 1/19/16, indicated to cleanse the right buttock with NS, pat dry and apply a Mepilex dressing. Change every other day. An "IDT Wound Review" dated 1/20/16 indicated, " ...Resident is followed for excoriation to bilateral buttocks and ...stage 2 pressure ulcer to right buttock ...Stage 2 pressure ulcer to Right buttock is improving and wound base presents with 80% granulation and 20% yellow slough, no drainage or odor to wound. Surroung (sic) tissue healty (sic) NP assessed area and new order for Medihoney with mepilex every 4 days and Mepilex boardered (sic) foam to be changed every other day. Frquency (sic) of Medihoney has been changed to help give the tissues regenerate .... " The wound review note lacked wound measurements. A Progress Note dated 1/27/2016 indicated, " ...History of present Illness ...Ulcer of right buttock cheek, continues/on going problem .... "			

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	The document "Stages of Pressure Ulcers" dated 2008, as referenced by the AMDA, (American Medical Director's Association) indicated, "...Stages of Pressure Ulcers...Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Note: This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to obtain proper antibiotic treatment for a UTI for 1 of 3 residents reviewed for appropriate treatment regimen for a UTI (Resident C). Resident was sent to the hospital and was place on Intravenous antibiotics and the facility failed to prevent a Urinary Tract Infection (UTI) for 2 of 3 residents reviewed for anchored catheter placement. (Residents #31 and #60) Findings include: 1. On 5/11/16 at 1:55 p.m., Resident C's record was reviewed. Diagnoses included, but were not limited to, generalized muscle weakness, dementia, leukocytosis (increase in the number of white blood cells in the blood, especially during an infection), history of bladder cancer, and recurrent UTI (urinary tract infection). A urine culture (test that helps your doctor figure out what treatment was needed to kill the bacteria) dated 4/4/16, indicated presence of a UTI. A physicians order dated 4/4/16, indicated Resident C was started on Ciprofloxacin (antibiotic) BID (twice a day) x10 (times 10) days for	F 0315	**F315 – NoCatheter, Prevent UTI, Restore Bladder What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·Resident # C - no longer resides at theCommunity. ·Resident # 31 –Nursing and C.N.A's re-educatedprior to survey exit regarding policy for Catheter care and management. ·Resident # 60 –Nursing re-educated prior tosurvey exit on current policy for Catheter care and management. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents with catheters residing in theCommunity have the potential to be affected by the alleged deficient practice. ·Licensed nurses and C.N.A.'s were re-educated onCatheter Care & Management, Universal precautions, Peri-Care and Glove useto reduce the risks of contamination, as well as, the procedure to follow whentransferring a Resident with a Foleycatheter placement. ·Licensed Nurses re-educated to ensureappropriate antibiotics are ordered and administered.	05/27/2016

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	UTI. A urine culture dated 4/4/16, indicated resistance (the ability not to be affected) to Ciprofloxacin. EMAR (electronic medication administration record) dated 04/2016, indicated Ciprofloxacin was given on the following days: 4/4/16 in the evening 4/5/16 4/6/16 4/7/16 4/8/16 4/9/16 4/10/16 in the morning A "Hospital History and Physical" dated 4/10/16, indicated "...The patient is going to be admitted under the care of [name of Hospitalist Service] with diagnosis humerus fracture...5. Urinary tract infection. Continue with Cipro 500 mg p.o. [by mouth] b.i.d. [twice daily] 6. Leukocytosis. Most likely secondary to fracture and the UTI...Past Medical History:...recurrent UTI, most recently diagnosed on April 4...Diagnostic Data:...White blood cells 12.9...." A "Hospital Discharge Summary", dated 4/15/16, indicated "...Discharge Diagnoses...2. ESBL [Extended-Spectrum Beta-Lactamase] UTI on IV meropenem [an antibiotic		**What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·Licensed nurses were re-educated on the policyand procedure for Catheter care and prevention, UTI prevention and InfectionControl to prevent the spread of infection. ·DON/designee will monitor the Catheter care andmanagement for proper placement and Infection control to prevent the spread ofinfection, for 2 residents per week for 4 weeks. ·Licensed nurses and C.N.A's have beenre-educated on Proper Catheter care, Peri-Care, and Management and/or UTIprevention, competency check list for proper protocol will be on-going. ·Licensed nurses re-educated on appropriateantibiotic usage. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·Licensed nurses re-educated on the policy andprocedure for Catheter Care and management, Peri Care, proper placement ofCatheter during transfers, UTI prevention. ·The Director of Nursing Services or her designeewill conduct 3 audits on Catheter Care and Management, on	

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	medication] for a total of 10 days. She has 1 week left... [Resident] has a history of recurrent UTI and has been on Cipro [Ciprofloxacin] for a while... Her urine looked cloudy when they inserted the catheter during surgery and urine culture was sent. Unfortunately, the patient was on Cipro at that time, but she had another urine culture at [name of facility] on April 1 which we were able to obtain the result of that which showed ESBL organism. We consulted ID [Infection Disease] where they recommended Merrem [an antibiotic medication] IV antibiotic which was sensitive and this was started on April 13. The plan for the patient is to go back to [name of the facility]... to continue the IV meropenem for a total of 10 days... As of today...white blood count 8.3...." A care plan dated 4/15/16, was reviewed, which indicated the following "... [Resident C's name] has a UTI infection...(G) [Resident C's name] will be clear of infection at conclusion of antibiotic course and will not require outside medical intervention...(A) Administer antibiotics as ordered. Observe for side effects and effectiveness and report concerns/worsening symptoms to physician promptly...(A) Meropenem [antibiotic]...Administer [dose] Q 12 [every 12] hours x7 [times 7] days for		residents with Foleycatheter, and appropriate antibiotic usage weekly for four weeks, monthly for threemonths and then quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	UTI...." 2. Resident #31's record was reviewed on 5/9/16 at 8:42 a.m. Diagnoses included, but were not limited to, retention of urine and hypertrophy of the prostate with urinary obstruction. The Electronic Medication Administration Record dated May 2016, included, but was not limited to, the following orders: 9/15/15--Monitor catheter integrity and position of catheter bag every shift. 12/16/15--Cipro (an antibiotic medication) 500 mg (milligrams) by mouth one time before any catheter change scheduled or as needed. The resident had a Care Plan dated 1/12/16, which indicated he had an indwelling catheter use with potential for infection for the diagnosis of urinary retention. Approaches included "1/12/16--1. Maintain closed drainage system. 2. Secure catheter to leg to avoid tension on urinary meatus. 3. Change catheter and/or drainage bag(s) per facility protocol or as ordered by PCP [Primary Care Physician]... to assure patency...5. Monitor for signs of UTI, such as change in color or consistency, a foul odor, or blood in urine, suprapubic, flank, or abdominal pain, fever, and			

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	advise physician...." Progress notes dated on the following dates indicated the following: On 10/25/15, the resident had a Urinary Tract Infection (UTI) and was ordered Bactrim DS (double strength) (an antibiotic medication) twice a day by mouth for 14 days for diagnosis of UTI. On 10/27/15, the resident's medication for his UTI was changed to Cipro 500 mg twice a day by mouth and the Bactrim was stopped. On 12/24/15, the resident was placed on Macrobid (an antibiotic medication) 100 mg twice a day by mouth for 14 days for diagnosis of UTI. An IDT (Interdisciplinary Team) note dated 12/26/15, indicated the resident had green tinged urine after insertion of a new foley catheter on 12/23/15. He was started on an antibiotic for a UTI. On 12/28/15, the resident's Macrobid was stopped and he was started on Ampicillin (an antibiotic medication) 500 mg by mouth four times a day for 10 days due to the urine culture results. On 5/9/16 at 10:05 a.m., CNA #8 and LPN #9 was observed transferring			

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	Resident #31 to bed with a mechanical lift. After donning clean gloves, LPN #9 placed the mechanical lift sling behind the resident. CNA #8 removed the resident's catheter drainage bag from the dignity bag on his wheelchair and hung it with the white hook from the front of his pants by the waistband of his pants. The catheter tubing had clear yellow colored urine in the tubing going from the drainage bag to the top of the catheter tubing. The resident was transferred with the mechanical lift back to his bed while the catheter drainage bag hung from his waistband of his pants. After the transfer was complete, LPN #9 removed the catheter bag from his waistband and placed it onto the bed frame by the white hook and sat the drainage bag in a wash basin on the floor. During an interview on 5/9/16 at 10:20 a.m., with LPN #9 and CNA #8 in attendance, LPN #9 indicated the catheter drainage bag should have been held during the transfer because the catheter drainage bag was above the resident's bladder and that was a risk for infection. 3. On 5/6/16 at 4:00 p.m., the record was reviewed for Resident #60. Diagnoses included, but were not limited to, benign prostatic hyperplasia (enlargement of prostate) and urinary retention.			

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	A care plan for Resident #60 dated 11/3/15, indicated the following, "...(P) [Resident name] has an indwelling catheter use with potential for infection... Dx: [Diagnoses] BPH [Benign Prostatic Hyperplasia] with Urinary Retention...(A) Provide catheter care per order...(A) Keep tubing below level of bladder and free of kinks and twists...." A physician's order dated 2/14/16, indicated an order for Augmentin (antibiotic) 1 tab (tablet) PO (by mouth) daily routine for UTI (urinary tract infection) prophylaxis (measure taken to maintain health and prevent the spread of disease). On 5/9/16 at 10:31 a.m., CNA #13 was observed taking Resident #60's urinary catheter drainage bag and holding it above the level of his bladder, then proceeded to place the catheter drainage bag onto the bed in between the legs of Resident #60. At that time, hazy yellow colored urine was observed in the tubing of Resident #60's catheter. During an interview on 5/9/16 at 3:25 p.m., the DON (Director of Nursing) indicated the urinary catheter drainage bag was supposed to be positioned below the level of the bladder to prevent reflux of urine into the bladder. During an interview on 5/10/16 at 9:20 a.m., CNA #12 indicated the urinary catheter drainage bag should be			

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	positioned below the level of the abdomen and maintain the catheter drainage bag at the lowest position possible while transferring the urinary catheter drainage bag. During an interview on 5/10/16 at 2:33 p.m., LPN #1 indicated the urinary catheter drainage bag should be kept below the level of the bladder to prevent the reflux of urine into the bladder. LPN #1 further indicated to lower the foot of the bed to slide the urinary catheter drainage bag across the foot of the bed to prevent positioning the urinary catheter drainage bag above the level of the bladder. A current policy titled "Infection Control" dated 11-1-13, provided by the DON on 5/11/16 at 3:45 p.m., indicated "...Objective:...To prevent the spread of infection...Guideline:...1. Licensed Nursing Home will monitor and investigate causes of infection and manner of spread...2. A record will be maintained that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of infection, and describes what cautionary measures were taken to prevent the spread of infection...6. Licensed Nursing Home implements Universal Precautions [utilizing			

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	protective barriers, such as gloves, gowns, and masks to reduce the risk of contamination]...." A current policy titled "Catheter Care" undated provided by the DON on 5/9/16 at 5:15 p.m., indicated "...Steps...8. If indwelling urinary catheter is present...a. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum [the area between the anus and the scrotum or vulva]. Keep drainage bag below level of bladder...." A current policy titled "Indwelling urinary catheter (Foley) care and management" undated, provided by the Director of Nursing on 5/9/16 at 5:15 p.m., indicated "...Keep the drainage tubing free from kinks and keep the drainage bag below bladder level...." 3.1-41(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident			

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	environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to assess and implement effective preventive interventions to prevent further falls for 1 of 3 residents reviewed for falls (Resident M). These falls for Resident M resulted in lacerations to her bilateral lower extremities, which required sutures to the right lower extremity and a fractured left lower femur. Findings include: The record for Resident M was reviewed on 5/9/16 at 8:39 a.m. Diagnoses included, but were not limited to, fracture of the left lower femur, dementia, muscle weakness, anxiety, falls, and fracture of the left hip. A Significant Change Comprehensive MDS (Minimum Data Set) assessment dated 3/23/16, indicated the resident scored an 8 on her BIMS (Brief Interview for Mental Status), which indicated she was moderately cognitively impaired. She was continent of bladder with occasional bowel incontinence. She was not on a toileting plan. She required assistance of one person with transfers,	F 0323	**F323 – Free ofAccident Hazards/Supervision/Devices** **What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident # M- residents chart reviewed, residentassessed, care plan interventions put in place, therapy and lifestylesconsulted. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action (s) will be taken:** ·All residents in the community have thepotential to be affected by the alleged deficient practice. ·A review of residents with falls, in the past 90days, was completed, care plans were updated as needed. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Licensed nursing were re-educated on fall preventionand interventions. ·IDT will review all the falls that happen in thecommunity to ensure proper interventions and implementations are in place toprevent further falls.	05/27/2016

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	bed mobility, and toileting. A plan of care dated 3/25/16, indicated the resident had a problem of self care deficit and a potential for falls due to hip fracture, weakness, and immobility with a goal of the resident would have no fall related injuries while in the facility. The interventions included, but were not limited to, therapies as ordered, provide assistance with transfers and toileting, "FALL RISK, BLEEDING RISK", continence assessment on admission, put a sign in the resident's room that reminds her not to get up before calling for help, and staff to check on frequently. On 5/9/16, the following was observed: At 10:06 a.m., the resident was sitting in her room in her w/c (wheelchair) next to her bed and bathroom wall with the room door open and she was partially visible from the hallway. A sign attached to a pole was standing in the far corner of the room out of the direct line of vision of the resident's chair. The sign stated "Call and not fall" with a cartoon picture of a person falling. At 3:10 p.m., the resident was sitting in her w/c at the nurses desk. Her eyes were closed. Staff members were coming and going all around her, but did not		**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·IDT will review falls in the weekly risk meetingto ensure that effective preventative interventions are in place to preventfurther falls. ·Director of Nursing or Designee will complete aclinical audit of residents with falls weekly for four weeks, monthly for threemonths and then quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	continuously have the resident in their line of sight. At 3:23 p.m., the resident remained sitting in her w/c at the nurses desk. Her eyes were closed, but would open when a call alarm sounded at the desk. She stated "they make me jump". No staff were present at the desk or in the hallways adjacent to the desk. During an interview on 5/5/16 at 11:43 a.m., the Director of Nursing (DON) indicated the resident had a fall on 5/2/16. She was getting up out of bed and sat on the floor. The recommendation to prevent further falls was to check on the resident frequently. On 5/9/16 at 4:47 p.m., Resident M was observed sitting in her wheelchair. She complained her bottom hurt. RN #21 medicated the resident with a pain pill. RN #21 indicated at that time, Resident M did not usually want to lay down during the day, so she was kept her at the nurses desk to prevent her from falling. During an interview on 5/10/16 at 10:21 a.m., LPN #22 indicated Resident M got anxious and had "flashbacks" at various times during the day. He indicated she would yell out for her husband who was deceased. During those times, she was			

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	taken out to the nurses desk to sit in her wheelchair. During an interview on 5/11/16 at 11:08 a.m., RN #21 indicated the staff would bring Resident M in her wheelchair to sit at the nurses station, so she did not fall. On 5/9/16 at 4:00 p.m., the DON provided copies of the facility's "Occurrence Reports" for Resident M's falls. They indicated the following: On 2/7/16 at 4:20 p.m., the "resident was found on the floor...laying sideways with her head leaning on the wall...She stated '...she was going to use the commode to toilet, to toilet herself.'" Immediate actions taken included, but were not limited to, "toileting program" and "commode toilet placed out of site". Conclusion statement entered by the DON on 3/4/16 at 9:13 a.m., indicated the "resident is confused at times...going to use the commode. Re-education on call light use and staff to check on resident frequently". On 3/2/16 at 6:05 a.m., the resident was found sitting on the floor in her room. She told staff she was trying to get in her wheelchair. The report indicated the resident was oriented to herself only and she had been toileted at 5:45 a.m.			

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	Immediate actions taken were to "place in bed, refer to physician, re-direct, keep under continuous supervision, and head to toe body check". Follow up recommendations on 3/4/16 at 9:31 a.m., indicated the resident was forgetful, forgot to call for help, and staff would continue checking on the resident frequently. On 3/7/16 at 6:45 p.m., the resident was found in her bathroom sitting in front of the toilet with her legs straddling the toilet between the toilet and toilet riser. She stated she went to get off the toilet and fell. A Nurse's note indicated a copious amount of blood was on the bathroom floor and on both of the resident's legs. She had a large laceration on the right leg, which was bleeding "profusely with blood clots coming from the wound". She had a skin tear on the left lower leg. Immediate actions taken included, but were not limited to, application of pressure dressing, placed in wheelchair, kept under continuous supervision, locate closer to nursing station and non-emergency transfer to hospital. She was transported to the hospital at 8:45 p.m. She returned to the facility with sutures and steri-strips to wounds on both lower legs A Nurses note dated, 3/8/16 at 11:01			

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	p.m., indicated resident continued to try to transfer herself from bed. A Nurses note dated, 3/9/16 at 6:15 p.m., indicated resident had gone to a follow up doctor's appointment and was admitted to the hospital. A Hospital Consultation report dated 3/9/16 at 1:23 p.m., indicated the resident was seen for follow up to her left hip surgery done on 1/21/16. During the appointment, the resident was found to have "another left femur fracture". A Nurses note dated 3/16/16 at 4:30 p.m., indicated the resident was readmitted to the facility with a diagnosis of left femur fracture. A Nurses note dated 3/17/16 at 8:18 a.m., indicated the resident was alert to name only. She was educated on the importance of asking for staff assistance and was compliant the majority of the shift. At 9:39 p.m., a nurse's note indicated the resident was attempting to transfer herself. An Occurrence Report dated 3/21/16 at 6:43 a.m., indicated a recommendation was made to place a sign in Resident M's room to remind her not to get up without calling for help.			

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	On 5/2/16 at 7:35 p.m., the resident was noted getting out of bed when she took a step backwards and landed on her buttocks on the floor by her bed. Immediate actions taken included, but were not limited to, place in wheelchair and take to the nurses station. Follow up recommendations to prevent further falls on 5/5/16 at 9:20 a.m., documented, were staff would continue to check on resident frequently. During an interview on 5/10/16 at 4:45 p.m., the DON indicated Resident M was checked on frequently by staff to prevent further falls. She did not indicate how often staff were to check on the resident. Resident M's plan of care, nursing notes, "Occurrence Reports", nor Interdisciplinary team notes (IDT) indicated any other interventions. A current policy titled "Team Resource For Resident Interventions to Prevent Falls" form was provided by the DON on 5/10/16 at 4:45 p.m., indicated suggested interventions for residents "Unable to Transfer Self", "Falls with Cognitively Impaired Residents", "Fall out of Wheel Chair" and "Residents with Multiple Falls" included, but were not limited to, "...contour mattress, body pillows for positioning...bed alarm to alert staff to			

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	position changes, toileting schedule, assess for need for pain meds, mat beside bed, offer fluids and snacks between meals...TABs to alert staff to position changes...rocking chair, seat chair alarm...Ask families to make activity basket...trending of falls for the individual-time of day, reason for fall, location fall etc...involve recreation for activity interventions: favorite TV programs, radio shows for high risk times, hydration group activity during risk times.... " This Federal tag relates to Complaint IN00198124 and IN00198238. 3.1-45(a)(2)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).			

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	- Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the staff posting included the information for an accurate census and the actual and total hours of the nursing staff working for 4 of 4 days observed during the annual survey. This had the potential to impact 39 of 39 residents residing in the facility (May 4, 9, 10, and 11, 2016). Finding includes: On 5/4/16 at 10:15 a.m. during the initial tour, on 5/9/16 at 10:38 a.m., on 5/10/16 at 9:43 a.m., and on 5/11/16 at 10:58 a.m., information for the staff posting included the census of 96 on each day with the names of the staff members only	F 0356	**F356 Posted NurseStaffing information What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Theactual staffing hours and census are posted daily. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All resident's have the potential to be affectedby the alleged deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not**	05/27/2016

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	indicated for each shift. No actual work or total hours worked were indicated for licensed or non-licensed nursing staff. During an interview on 5/11/16 at 5:10 p.m., the Director of Nursing indicated she was unaware she was to include the actual and total hours worked for licensed and non-licensed nursing staff and was only listing the names of the staff and identifying the 8 hour shifts. She also indicated she was including the residential and Medicare census as the total census, which was not accurate.		**recur:** ·Directorof Nursing Services or designee will post the census and actual and total hoursworked each day. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·TheHealth Facility Administrator (HFA) or designee will audit the posted hours. These audits will be completed weekly for fourweeks, monthly for three months and then quarterly thereafter for twelvemonths. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	
F 0365 SS=D Bldg. 00	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure a resident received the correct diet for 1 of 5 residents reviewed for diets (Resident M). Finding includes:	F 0365	**F365 Food in formto meet individual needs What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Resident M's diet has been reviewed, by theRegistered Dietitian, and is accurate. Dietary and Nursing staff have been	05/27/2016

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	On 5/9/16 from 11:42 p.m. to 1:05 p.m., during the dining room observation Resident M was observed to receive a regular diet consisting of french dip shredded roast beef sandwich with rosemary potatoes. During an interview, at that same time, the resident indicated her sandwich had a lot of bread with it. She was observed to eat 2/3 of the sandwich. During an interview on 5/9/16 at 1:05 p.m., the Dietary Manager indicated the mechanical soft diet for this meal was to be a slurry consistency for the bread and rosemary potatoes, which Resident M did not receive. Resident M's record was reviewed on 05/09/2016 at 8:39 a.m. Diagnoses included, but were not limited to, anxiety, dementia, gastroesophageal reflux disease, and chronic obstructive pulmonary disease. The physician's orders included, but were not limited to, the following: On 3/30/16 speech evaluation for difficulty swallowing and assess for proper diet; On 3/30/16 order for mechanical soft diet with thin liquids. This Federal tag relates to Complaint		educated on serving the residentsthe proper diet and reviewing tray tickets. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All resident's have the potential to be affectedby the alleged deficient practice. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·TheDining Services Director (DSD) or designee conducted in-services on followingdiet order with correct meals. ·Nursingstaff will verify the meal ticket and meal before delivering the meal to theresident. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The RegisteredDietitian or designee will conduct audits on following diet order with correct meals. These audits will be completed weekly for fourweeks, monthly for three months and then quarterly thereafter for twelvemonths. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	IN00198124. 3.1-21(a)(3)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen. This deficiency had the potential to affect 39 of 39 residents who received food from the kitchen. Findings included: The initial kitchen tour began on 5/4/16 at 10:00 a.m., with the DSD (Dining Services Director). The following observations were made in the walk in cooler: One bag of uncontained and undated ropes of sausage were sitting on the second shelf.	F 0371	**F371 Food procure,store/prepare/serve-sanitary What corrective action (s) will be accomplished forthose residents found to have been affected by the deficient practice:** ·Noresident was found to be affected by this alleged deficient practice. ·Allresidents have the potential to be affected. ·Allareas identified of allegedly deficient practice were corrected promptly. **How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective action(s)will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. All areas identified as allegedlydeficient were addressed promptly. **What**	05/27/2016

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	One bag of undated and uncontained churros were sitting on the third shelf. One clear plastic container with cloudy fluid and fresh parsley was sitting on the second shelf. The parsley was not contained within the container and touched the rear of the cooler wall. One bag of open and undated fresh broccoli florets were on the second shelf of the walk in cooler. One bag of open and undated fresh salad greens were positioned on the second shelf. The following observations were made in the walk in freezer: One box of open and undated frozen mixed vegetables that contained 10 of 12 bags. One box of open and undated frozen corn that contained 9 of 12 bags. One box of open and undated Mozzarella sticks that contained 2 of 6 bags. The large, stationary blender was covered with a plastic cover splattered with food debris and residue.		**measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:** ·TheDining Services Director (DSD) or designee conducted in-services on properprocedure for obtaining temperatures for food/immersion time and keyrequirements for sanitizing 3 compartment sink/ food storage/dating/labeling/serving and following diet order with correct meals/hair netusage and proper food handling with glove usage/cleaning of equipment andfollowing cleaning schedules. ·The DSDor designee will conduct audits on proper procedure for obtaining temperatures forfood/immersion time and key requirements for sanitizing 3 compartment sink/food storage/ dating/labeling/serving and following diet order with correctmeals/hair net usage and proper food handling with glove usage/cleaning ofequipment and following cleaning schedules. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:** ·TheRegistered Dietitian (RD) or designee will conduct audits on proper procedure forobtaining temperatures for food/immersion	

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	The hand blender motors were stored uncovered on the lower shelf of a metal prep table and were covered with dust and food debris. The upper and lower levels of the metal prep table were sitting beside the grill and had spatters of food debris and grease. A large plastic, uncovered storage bin contained mixer attachments and food preparation equipment had moderate amounts of food debris and dust in the container. The bin was positioned on the lower shelf of a food prep table. On 5/4/16 at 1:07 p.m., a second kitchen observation was made. Chef #16 was observed at that time, washing and preparing fresh grapes in a colander without gloves. She was not wearing a hair net. On 05/04/2016 at 1:08 p.m., Dietary Server #15 was observed in the kitchen without a hairnet. During an interview on 05/04/2016 at 1:12 p.m., Chef #16 indicated everyone in the kitchen must wear a hair net. She touched her hair and head while she was standing at the sink where she had been washing grapes. At that time, she indicated her hair net had fallen off.		time and key requirements forsanitizing 3 compartment sink/food storage/ dating/labeling/serving andfollowing diet order with correct meals/hair net usage and proper food handlingwith glove usage/cleaning of equipment and following cleaning schedules. These audits will be completed monthly forthree months and then quarterly thereafter for twelve months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	On 05/04/2016 at 1:30 p.m., the three compartment sink was labeled as follows, "Wash" on the first compartment, "Rinse" on the second compartment and "Sanitize" on the third compartment. The first compartment labeled "Wash" contained soapy water. The second compartment labeled "Rinse" contained pink-tinged water and the third compartment labeled "Rinse" contained clear water. At that time, the DSD tested the second compartment containing pink-tinged water for level of sanitizer in the water. The DSD indicated the sinks were filled incorrectly, as the sanitizing water should have been in the third compartment labeled "Sanitize". On 05/09/2016 at 10:51 a.m., the 3 compartment sink was observed. In the first compartment labeled "Wash" was soapy water and a large stock pot. The second compartment labeled "Rinse" contained pink-tinged water. The third compartment labeled "Sanitize" contained clear water. The DSD indicated at that time, the sinks were filled incorrectly and should have contained the sanitizing solution in the third compartment labeled "Sanitize" and the rinse water in the second compartment labeled "Rinse". On 05/09/2016 at 11:35 a.m., Cook #18			

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	was observed obtaining food temperatures of the diced tomatoes, the diced salami and lettuce leaves without cleansing the thermometer between each food item. At that time, Cook #18 indicated he should have cleansed the thermometer after each food item before obtaining a temperature for the next food item. A current undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled, " STANDARDS & GUIDELINES. Section: Dining Services. Subject: Dress Code, indicated ...5. Hair net or hair restraints are to be worn .... " A current, undated, untitled document provided by the DSD on 05/09/16 at 5:30 p.m., indicated "410 IAC 7-24-138 Effectiveness of hair restraint...food employees shall wear hair restraints, such as hats, hair coverings or nets ...that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils .... " A current, undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled "STANDARDS & GUIDELINES " indicated, " Section: Dining Services. Subject: Storage guidelines ...REFRIDGERATION ...5. Food should be covered, dated...7. All meats should			

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	be bulk portioned, wrapped in freezer wrap and labeled for meals before storage ...12. All foods in the freezer are ...to be labeled and dated .... " A current, undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled, " STANDARDS & GUIDELINES " indicated, " Section: Dining Services. Subject: Sanitizing Pots, Pans and Small Utensils (3 Compartment) ...Guideline:..2. Measure detergent into wash sink; fill ¾ full (first compartment) ...4. Fill the rinse sink ¾ full (second compartment). 5. Fill sanitizing sink ¾ full and add the sanitizing agent (third compartment)...." 3.1-21(i)(2)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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	(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to follow proper infection control measures in regards to proper glove use and disposal for 2 of 2 residents reviewed for personal care (Residents #60 and #61). Findings include: 1. On 5/6/16 at 4:00 p.m., Resident #60's record was reviewed. Diagnoses included, but were not limited to, benign	F 0441	**F441 – InfectionControl Prevent Spread, Linens What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident # 60, #61 – re-education was done tonursing staff for proper glove use when there is contact with bodily fluids. ·C.N.A. # 13 and C.N.A. # 2 was immediately in-servicedon proper glove use and corrective action implemented.	05/27/2016

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	prostatic hyperplasia (enlargement of prostate) and urinary retention. Physician's orders included, but were not limited to, Augmentin (antibiotic) one tab (tablet) PO (by mouth) daily routine for UTI (urinary tract infection) prophylaxis (use of medication to prevent infections) with an order date of 2/14/16. On 5/9/16 at 10:40 a.m., CNA (Certified Nursing Assistant) #13 was observed emptying brown colored urine from Resident #60's urinary catheter bag into a urinal. CNA #13 proceeded to empty the brown colored urine from the urinal into the toilet. CNA #13 rinsed the urinal in the sink and disposed the water into the toilet. CNA #13 touched Resident #60's bedside table to grab alcohol wipes and opened Resident #60's nightstand with the handle to place the alcohol wipes in the top drawer while wearing the same gloves utilized during catheter care. CNA #13 took her gloves off and performed hand hygiene. On 5/9/2016 at 3:27 p.m., the DON (Director of Nursing) indicated gloves should be changed when there was contact with bodily fluids. 2. On 05/10/2016 at 9:49 a.m., Resident #61' s personal care was observed. CNA		**How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action (s) will be taken:** ·All Residents in the community have thepotential to be affected by the alleged deficient practice. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Nursing personnel in the Community werein-serviced on the glove use policy. The in-service training included random observations of personnel usinggloves according to the Infection Control policy. Competencies are completed with personneland the procedure is reviewed annually at orientation and with all newhires. Corrective actions is implementedfor failure to follow the policy correctly. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·Director of Nursing/designee will complete 3 validationchecklists of personnel on all shifts. Three Employees will have their proper glove use and techniquesevaluated per Infection Control weekly for four weeks, monthly for three monthsand then	

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	#2 was observed to don a pair of gloves, cleansed the resident's rectal area, and then, washed around his penis and scrotal area. Wearing the same gloves, CNA #2 redressed the resident with a new brief, pulled his pants up and transferred him back with the standup lift to his wheelchair. Wearing the same gloves, she rearranged his clothing and rinsed his urinal in the bathroom sink. She removed her gloves and washed her hands. At that time, CNA #2 indicated she should change her gloves if she touched " bm " (bowel movement), but the resident did not have a bm. A current procedure titled "Indwelling Urinary Catheter Care and Management" undated was provided by the DON on 5/9/16 at 5:15 p.m., indicated "...perform hand hygiene...put on necessary personal protective equipment [equipment designed to protect the wearer's body from injury or infection such as gloves]...keep the drainage tubing free of kinks and keep the drainage bag below bladder level...properly dispose of used supplies...remove and discard your personal protective equipment..perform hand hygiene...." 3.1-18(b)(1)(B) 3.1-18(l)		quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	155817	A. BUILDING 00 B. WING	05/12/2016

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F 0508 SS=D Bldg. 00	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure an X-ray exams were performed in a timely manner for 1 of 3 residents reviewed for timely X-ray services (Resident C). Finding includes: An "Occurrence Report" dated 4/8/16 at 9:00 a.m., indicated Resident C had a fall in her room during a transfer with CNA #8 as a witness. "At 9:00am today resident transferring from w/c [wheelchair] to recliner with assist x [times] 1. During transfer resident lost her balance and began to fall to the right. CNA attempt to assist resident and lowered resident to floor. Resident did hit her right shoulder and arm on the floor. Resident c/o [complained of] of severe pain to right shoulder. No other s/s [signs/symptoms] of injury noted at this time. PPP [peripheral pulses present] x4. Assist x 2 to remove resident from floor. Resident displayed	F 0508	**F508 –Provide/Obtain Radiology/Diagnostics Svcs** **What correctiveaction (s) will be accomplished for those resident found to have been affectedby the deficient practice:** ·Resident # C no longer resides at the community. ·Education provided for nursing staff on orderingdiagnostic testing and testing andfollowing up for results. **How other residents having the potential to be affected by the samedeficient practice will be identified and what corrective action (s) will betaken:** ·All residents have the potential to be affectedby the alleged deficient practice. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** ·Licensed nurses have been re-in-serviced on theradiology policy and procedure concerning	05/27/2016

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	limited ROM [range of motion] in RUE [right upper extremity] compared with LUE [left upper extremity]. NP [Nurse Practitioner] and daughter notified. N. O. [new order] obtained for x-ray of right shoulder, elbow and humerus." Resident statement of what happened was documented 4/11/16 at 12:22 p.m., "I don't know it just hurts." Resident guarding right shoulder following fall. Witness statement of what happened was documented on 4/11/16 at 12:22 p.m., "I was transferring resident from her w/c to the recliner when she started leaning to the right. I attempt to 'catch her' but I couldn't so I assisted in lowering her to the floor. Resident landed on her right shoulder and right upper extremity. Resident did not hit her head. Assist x 2 to remove from floor." The injuries section indicated the resident displayed limited range of motion and complaints of pain in the right shoulder and arm following the fall. The NP was notified of the fall on 4/8/16 at 9:15 a.m., with new orders. The family member was notified of the fall on 4/8/16 at 12:00 p.m. Resident C's record was reviewed on 5/9/16 at 4:18 p.m. Diagnoses included, but were not limited to generalized muscle weakness, atrial fibrillation and dementia.		times and status of service byDirector of Nursing or Designee. Nursing Staff educated to contact DNS ordesignee if unable to obtain diagnostic report in appropriate time frame. ·Licensed nurses have been re-in serviced oncommunity's notification of changes policy. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·IDT will review 3 reports and clinical records to ensure timeliness of exams wereperformed/completed during clinical meetings and the documentationreflected. Clinical records of concernwill be investigated and correction done. ·Director of Nursing or Designee will audit 3 chartsof residents with exams ordered/ done, and review to ensure exams wereperformed and completed in a timely manner. ·The DNS/designee will conduct a clinical recordaudit on residents with exams weekly for four weeks, monthly for three monthsand then quarterly thereafter for 12 months. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	

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	Resident C's Physician orders included, but were not limited to, the following orders: 4/8/16--Three view shoulder X-ray of the right shoulder and two view humerus X-ray for a recent fall and severe pain. (The stat box on the order was not checked) 4/8/16--X-ray of right elbow, right radius and ulna. (The stat box on the order was not checked). 4/8/16--May send to ER for X-ray of right elbow and right radius and ulna, ice to right elbow every 4 hours as needed for pain for 20 minutes--avoid direct contact, sling for right upper extremity continually for pain control. A Radiology Report dated 4/9/16, indicated the resident had a shoulder X-ray completed on 4/9/16, for pain after a fall. The results indicated there was an acute mildly displaced proximal humeral fracture. A Radiology Report dated 4/9/16, indicated the resident had an elbow X-ray completed on 4/9/16, which indicated there was an acute mildly displaced fracture of the distal humerus. There was also soft tissue swelling. A Radiology Report dated 4/9/16,			

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	indicated the resident had a forearm X-ray completed after a fall. The results indicated there was no fracture or dislocation. During an interview on 5/9/16 at 8:31 p.m., the resident's family member indicated the resident had two fractures of her right arm. She indicated she had chosen not to take her to the ER the day she fell to get an X-ray of her right shoulder and arm because the X-rays had been ordered at the facility and she did not have any idea it would take until mid day on 4/9/16, to get the X-ray performed or until 3:00 p.m. on 4/9/16, to get the X-ray results back and the results called to the NP on call when the X-rays were ordered on 4/8/16 in the morning. She indicated the resident had to wait for over 24 hours for the X-rays to be completed from the time they were ordered. During an interview on 5/10/16 at 9:38 a.m., Customer Service Dispatcher #19 from (name Radiology company) indicated the X-ray test requests were sent to them as a normal exam request on 4/8/16 at 12:46 p.m., then the X-rays were upgraded to a "Stat" request on 4/9/16 at 8:07 a.m. She indicated a "Stat" request was completed in two hours depending on how many other stats were needed to be completed in the area the			

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	resident was in, but they tried to get the stats completed in two hours. During an interview on 5/10/16 at 11:41 a.m., Field Supervisor #20 from the (name Radiology company) indicated if an X-ray was ordered as a normal order it should be completed within 24 hours and if it was ordered as a "Stat" it should be completed within four hours depending on how many procedures had been ordered as stats. He indicated an X-ray could always be upgraded as a "Stat". He indicated the resident's X-ray could have been ordered as a stat and it would have been completed on 4/8/16. During an interview on 5/10/16, at 3:41 p.m., the DON indicated the resident's family member declined to have her sent to the ER to have her evaluated and treated, but she could not find in the resident's documentation where the family member declined to pay for stat X-rays. During an interview on 5/11/16 at 11:09 a.m., the DON indicated as soon as the nurses get the order for the X-rays, she expected them to notify the (Name of the Company), which did the X-rays for the facility, the X-rays were needed. During an interview on 5/11/16 at 2:10			

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	p.m., RN #11 indicated she called the (Name of the X-ray Company) for the X-ray after 12:00 p.m. on 4/8/16, to request the X-rays be completed A.S.A.P. (As Soon As Possible). She indicated if the X-rays were called in as an A.S.A.P., then the technicians will come out and do the X-rays within six hours of calling the request for the X ray in. RN #11 indicated she did not document in the resident's record she called for the X-rays A.S.A.P. During an interview on 5/12/16 at 9:49 a.m., the Administrator indicated she expected the nurses should call (Name of X-ray Company) or to call the DON or the Nurse Manager and notify them an X-ray had not been done in the allotted time frame. A current policy titled "[Name of Company] USA Policy and Procedure Concerning Times and Status of Service" undated, provided by the DON on 5/11/16 on 2:18 p.m., indicated "STAT ORDERS" Tech will arrive within 2 hours from time exam is ordered with results within 4 hours. Total time from time ordered until results are in 4 hours... ASAP ORDERS: Tech will arrive within four hours from the time exam is ordered with results within hours. Total time from time ordered until results are in 6			

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	hours...NORMAL ROUTINE OR FOLLOW UP EXAMS: The tech will arrive in that day's business with results that same day. If it is an evening order the tech will arrive in that evening with results in the same evening. You will have your results in the same business day with the only exception being that the order was placed very late in evening and by the time the Radiologist reads it and we send report it is after Midnight then the date would change to next day. If the exam is ordered NORMAL and the symptoms worsen the nurse can always call in to our call center and upgrade order to a STAT. This will be paged out to tech and the above STAT timeframe would begin to apply...." This Federal tag relates to Complaint IN00198238. 3.1-49(g)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey.	R 0000	Please accept this 2567 Plan of Correction for the HealthSurvey ending May 12, 2016 as a Provider's Letter of Credible Allegation. This provider respectfully	

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	Residential Census: 66 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.		requestsconsideration for paper compliance in lieu of a revisit survey for this Plan ofCorrection with a completion date of May 27, 2016. This Plan of Correction constitutes my writtenallegation of compliance for the deficiencies cited. However, submissionof this Plan of Correction is not an admission that a deficiency exists or thatone was cited correctly. This Plan of Correction is submitted to meetrequirements established by state and federal law.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which			

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	they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and First Aid certified staff member in the facility available for residents at all times. This deficient practice had the potential to affect 66 of 66 residents currently residing in the facility. Finding includes: The CPR and First Aid certifications were reviewed on 5/12/16 at 1:15 p.m. There were no staff members available on duty for the 3:00-11:30 p.m., shift with CPR and First Aid certifications for the following dates: 5/5/16, 5/6/16, 5/7/16, 5/10/16 and 5/11/16. During an interview on 5/12/16 at 3:15 p.m., the Administrator indicated she had provided all the CPR and First Aid certifications she had available for her staff.	R 0117	**R117- Personnel –Deficiency It is the practiceof this Community to ensure CPR (cardiopulmonary resuscitation) and First Aidcertified staff member in the facility are available for residents at alltimes. What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·No residents were found to be negativelyaffected. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. The Community will ensure there is onestaff member on duty that is CPR and First Aid certified at all times. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·AL Coordinator or designee will develop aschedule with certified First Aid and CPR staff on duty each shift. ·Provide On-going CPR and First Aid training. **How the correctiveaction (s) will be monitored to ensure the**	05/27/2016

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			deficient practice will not recur,i.e., what quality assurance program will be put into place: ·AL Coordinator or designee will review schedulesto ensure there is a staff member on duty that is CPR and First Aid certifiedat all times. ·Findings of the audit will be monitored in theQuality Assurance Performance Improvement (QAPI) meeting.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.			

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	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure employees received Tuberculosis (TB) screening in the prescribed time frame for 2 of 10 employees screened for TB screening (LPN #5 and CNA #6). Findings include: The employee records were reviewed on 5/12/16 at 10:00 a.m. 1. There was no second step PPD (Purified Protein Derivative) (a skin test to determine if a person has been exposed to TB) test result found in LPN #5's employee record. 2. There was no annual PPD test result found in CNA #6's employee record. During an interview on 5/12/16 at 3:45 p.m., the Administrator indicated she had	R 0121	**R121-Personnel-Noncompliance It is the practiceof this Community to ensure that employees receive Tuberculosis (TB) screeningin the prescribed time frame** **What corrective action(s) will be accomplished for those residents found to have been affected by thedeficient practice**: ·No residents were negatively affected. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. The Community will ensure that staffhave received their TB screening in the prescribed time frame. ·All employee records reviewed for current TB compliance.	05/27/2016

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	no further PPD information to provide for LPN #5 or CNA #6.		**What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·The HR Director or designee will ensure that allnew hires and annual PPD (Purified Protein Derivative)/Chest X-Ray tests are in compliance **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The HR Director or designee will ensure that newhires and annual PPD's are given in the prescribed time frame. These audits will be completed quarterly fortwelve months. ·Findings of the audit will be monitored by theQuality Assurance Performance Improvement (QAPI) meeting.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen. This deficiency had the potential to affect 66 of 66 residents who received food from the kitchen.	R 0273	**R273-Food andNutritional Services-Deficiency It is the practiceof this Community to ensure the kitchen is maintained in a clean and sanitary manner. What corrective action (s) will be**	05/27/2016

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	Findings included: The initial kitchen tour began on 5/4/16 at 10:00 a.m., with the DSD (Dining Services Director). The following observations were made in the walk in cooler: One bag of uncontained and undated ropes of sausage were sitting on the second shelf. One bag of undated and uncontained churros were sitting on the third shelf. One clear plastic container with cloudy fluid and fresh parsley was sitting on the second shelf. The parsley was not contained within the container and touched the rear of the cooler wall. One bag of open and undated fresh broccoli florets were on the second shelf of the walk in cooler. One bag of open and undated fresh salad greens were positioned on the second shelf. The following observations were made in the walk in freezer:		**accomplished forthose residents found to have been affected by the deficient practice:** ·No residentwas found to be affected by this alleged deficient practice. ·Allresidents have the potential to be affected. ·Allareas identified of allegedly deficient practice were corrected promptly. **How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. All areas identified as allegedlydeficient were addressed promptly. **What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:** ·TheDining Services Director (DSD) or designee conducted in-services on properprocedure for obtaining temperatures for food/immersion time and keyrequirements for sanitizing 3 compartment sink/ food storage/dating/labeling/serving and following diet order with correct meals/hair netusage and proper food handling with glove usage/cleaning of equipment andfollowing cleaning schedules.	

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	155817	A. BUILDING 00 B. WING	05/12/2016

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	One box of open and undated frozen mixed vegetables that contained 10 of 12 bags. One box of open and undated frozen corn that contained 9 of 12 bags. One box of open and undated Mozzarella sticks that contained 2 of 6 bags. The large, stationary blender was covered with a plastic cover splattered with food debris and residue. The hand blender motors were stored uncovered on the lower shelf of a metal prep table and were covered with dust and food debris. The upper and lower levels of the metal prep table were sitting beside the grill and had spatters of food debris and grease. A large plastic, uncovered storage bin contained mixer attachments and food preparation equipment had moderate amounts of food debris and dust in the container. The bin was positioned on the lower shelf of a food prep table. On 5/4/16 at 12:53 p.m., during a meal service from the assisted living kitchen, Dietary Server #17 was observed eating a white, dry substance with his hands and drinking from a white, styrofoam cup.		·The DSDor designee will conduct audits on proper procedure for obtaining temperatures forfood/immersion time and key requirements for sanitizing 3 compartment sink/food storage/ dating/labeling/serving and following diet order with correctmeals/hair net usage and proper food handling with glove usage/cleaning ofequipment and following cleaning schedules. These audits will becompleted weekly for four weeks, monthly for three months and then quarterlythereafter for twelve months. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:** ·The Registered Dietitian (RD) or designee willconduct audits on proper procedure for obtainingtemperatures for food/immersion time and key requirements for sanitizing 3compartment sink/ food storage/ dating/labeling/serving and following dietorder with correct meals/hair net usage and proper food handling with gloveusage/cleaning of equipment and following cleaning schedules. Theseaudits will be completed monthly for three months and then quarterly thereafterfor twelve months.	

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	He left white crumbs on his lips when he finished. During that time, the DSD indicated no one should eat in the kitchen. On 5/4/16 at 1:07 p.m., a second kitchen observation was made. Chef #16 was observed at that time, washing and preparing fresh grapes in a colander without gloves. She was not wearing a hair net. On 05/04/2016 at 1:08 p.m., Dietary Server #15 was observed in the kitchen without a hairnet. During an interview on 05/04/2016 at 1:12 p.m., Chef #16 indicated everyone in the kitchen must wear a hair net. She touched her hair and head while she was standing at the sink where she had been washing grapes. At that time, she indicated her hair net had fallen off. On 05/04/2016 at 1:30 p.m., the three compartment sink was labeled as follows, "Wash" on the first compartment, "Rinse" on the second compartment and "Sanitize" on the third compartment. The first compartment labeled "Wash" contained soapy water. The second compartment labeled "Rinse" contained pink-tinged water and the third compartment labeled "Rinse" contained		· Findingsof the audit will be monitored in the Quality Assurance Performance Improvement(QAPI) meeting.	

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	clear water. At that time, the DSD tested the second compartment containing pink-tinged water for level of sanitizer in the water. The DSD indicated the sinks were filled incorrectly, as the sanitizing water should have been in the third compartment labeled "Sanitize". On 05/09/2016 at 10:51 a.m., the 3 compartment sink was observed. In the first compartment labeled "Wash" was soapy water and a large stock pot. The second compartment labeled "Rinse" contained pink-tinged water. The third compartment labeled "Sanitize" contained clear water. The DSD indicated at that time, the sinks were filled incorrectly and should have contained the sanitizing solution in the third compartment labeled "Sanitize" and the rinse water in the second compartment labeled "Rinse". On 05/09/2016 at 11:35 a.m., Cook #18 was observed obtaining food temperatures of the diced tomatoes, the diced salami and lettuce leaves without cleansing the thermometer between each food item. At that time, Cook #18 indicated he should have cleansed the thermometer after each food item before obtaining a temperature for the next food item.			

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	A current undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled, " STANDARDS & GUIDELINES. Section: Dining Services. Subject: Dress Code, indicated ...5. Hair net or hair restraints are to be worn .... " A current, undated, untitled document provided by the DSD on 05/09/16 at 5:30 p.m., indicated "410 IAC 7-24-138 Effectiveness of hair restraint...food employees shall wear hair restraints, such as hats, hair coverings or nets ...that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils .... " A current, undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled "STANDARDS & GUIDELINES " indicated, " Section: Dining Services. Subject: Storage guidelines ...REFRIDGERATION ...5. Food should be covered, dated...7. All meats should be bulk portioned, wrapped in freezer wrap and labeled for meals before storage ...12. All foods in the freezer are ...to be labeled and dated .... " A current, undated policy provided by the DSD on 05/09/16 at 5:30 p.m., titled, " STANDARDS & GUIDELINES " indicated, " Section: Dining Services. Subject: Sanitizing Pots, Pans and Small			

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	Utensils (3 Compartment) ...Guideline:..2. Measure detergent into wash sink; fill ¾ full (first compartment) ...4. Fill the rinse sink ¾ full (second compartment). 5. Fill sanitizing sink ¾ full and add the sanitizing agent (third compartment)...."			